Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
NVS4432HHA		NVS4432HHA		B. WING		05/11/2011		
NAME OF PROVIDER OR SUPPLIER			STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
CAPEALIEE HOME HEALTH AGENCY				WEST FLAMINGO ROAD SUITE 123 VEGAS, NV 89131				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE	
H 00	INITIAL COMMENTS			H 00				
	This Statement of Deficiencies was generated as a result of a abbreviated focused State Relicensure Survey conducted at your agency on 5/11/11, in accordance with Nevada Administrative Code, Chapter 449 Home Health Agencies.							
	The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions, or other claims for relief that may be available to any party under applicable federal, state, or local laws.							
	The agency's census Five patient files were One home visit was c Nine employee files w	e reviewed. conducted. vere reviewed.						
H153	The following deficiencies were identified: 449.782 Personnel Policies		H153					
	A home health agence policies concerning the responsibilities and concerning the responsibilities and concerning the responsibilities and concerning the responsibilities and concerning the personner of the staff of the personnel policies. The annual testing	y shall establish written ne qualification, onditions of employmer el, including licensure if written policies must be and made available to t and the advisory group	nt for e he s.					
		ot met as evidenced by: 175 is hereby amended naving tuberculosis or						

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Bureau of Health Care Quality and Compliance

		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBI		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
NVS4432HHA				B. WING		05/11/2011		
NAME OF PE	ROVIDER OR SUPPLIER		STREET ADDRE	SS, CITY, STA	ATE, ZIP CODE			
CARE4LIFE HOME HEALTH AGENCY			8665 WEST F LAS VEGAS,		ROAD SUITE 123			
(X4) ID PREFIX TAG				ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	E ACTION SHOULD BE COMPLETE D TO THE APPROPRIATE DATE		
H153	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		osis dent ol and graph ent or s of e for n e ol and graph oyed al a a te of and gious a step in the of the	H153				

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: A. BUILDING	TION (X3) DATE SURVEY COMPLETED
NVS4432HHA B. WING	05/11/2011
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/11/2011
CARE4LIFE HOME HEALTH AGENCY 8665 WEST FLAMINGO ROAD SUITE LAS VEGAS, NV 89131	123
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EA	ROVIDER'S PLAN OF CORRECTION (X5) COMPLETE COMPLETE DEFICIENCY) (X5) COMPLETE DATE
designee or another licensed physician determines that the risk of exposure is appropriate for a lesser frequency of testing and documents that determination. The risk of exposure and corresponding frequency of examination must be determined by following the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (h) of subsection 1 of NAC 441A.200. 4. An employee with a documented history of a positive tuberculosis screening test is exempt from screening with skin tests or chest radiographs unless he develops symptoms suggestive of tuberculosis. 5. A person who demonstrates a positive tuberculosis screening test administered pursuant to subsection 3 shall submit to a chest radiograph and medical evaluation for active tuberculosis. 6. Counseling and preventive treatment must be offered to a person with a positive tuberculosis screening test in accordance with the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (g) of subsection 1 of NAC 441A.200. 7. A medical facility shall maintain surveillance of employees for the development of pulmonary symptoms. A person with a history of tuberculosis or a positive tuberculosis screening test shall report promptly to the infection control specialist, if any, or to the director or other person in charge of the medical facility if the medical facility has not designated an infection control specialist, when any pulmonary symptoms develop. If symptoms of tuberculosis are present, the employee shall be evaluated for tuberculosis. Based on employee file review, the facility failed to ensure compliance with chapter 441A	

Bureau of Health Care Quality and Compliance

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NVS4432HHA				B. WING		05/	05/11/2011	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	ATE, ZIP CODE	•		
CARE4LIFE HOME HEALTH AGENCY				8665 WEST FLAMINGO ROAD SUITE 123 LAS VEGAS, NV 89131				
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H153	Continued From page 3			H153				
	employees (Employee	e #2, #3 and #7).						
			active ns oot ve					
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